OMB #
Expires:

SP ID #: _____

SP NAME: _____

INTERVIEWER NAME: _____

INTERVIEWER ID: _____

FACILITY ID #: _____

START TIME: _____ am/pm

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCE ADMINISTRATION

MEDICARE CURRENT BENEFICIARY SURVEY

FACILITY COMPONENT

EXPENDITURES

ROUND 22

OVERALL PROGRAMMING SPECIFICATIONS FOR FACILITY EXPENDITURES QUESTIONNAIRE

Reference Dates for Billing and Payments

1. Reference Start Date

If Round 18,
Set REFERENCE START DATE TO FAD/RAD if CFC, FFC or FCF identified in Round 18. Else, set REFERENCE START DATE to 1/1/97.

Else,
If CFR, set REFERENCE START DATE to the FIRST REFERENCE PERIOD AFTER THE DATE THROUGH WHICH THE FACILITY REPORTED COMPLETE BILLING RECORDS IN CRRD-1.
If CFC, SSM2, FFC, or FCF, set to RAD/FAD.
If SSM1, set to 1/1/{ENTRY YEAR}.
Note that, as described in the General Programming Instructions, the expenditures questionnaire is not administered for supplemental sample members until the winter/spring round following their entry year.

If the SP is deceased and date of death occurred on or before the date through which the facility had complete billing records last round, and the facility reported receiving all expected payments for this SP in CRRD-1 (EX20 and EX28 = "1"), then collection of expenditures for this SP is "NA".

2. Reference End Date for Billing.

If the SP is alive and in the facility on the date of interview, set the REFERENCE END DATE to the date through which the facility has complete billing records {EX4}; else

If the SP has been discharged alive from the facility, display {{EX5}/{MOST RECENT DATE OF DISCHARGE} whichever is latest; else

If the SP is deceased, display {{EX5}/{DATE OF DEATH}} whichever is latest.

3. Reference End Date for Payments.

In each round, set the Reference End Date for payments to {EX5}.

4. Medicaid Display.

In IN1 and IN6, display {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} by matching the state of the facility's address with a state in the table of State Medicaid Names included in Facility Questionnaire specifications.

MGMT SYSTEM SPEC. for all of EXPENDITURES:

1. Unless otherwise specified, allow DK and RF.

2. The following questions, which reference specified billing periods, should display the following header, centered:

{BP START EX8} - {BP END EX8}

EX10, EX10a, EX11, EX13, EX16, EX17, EX18, EX20, EX21, EX21b, EX22, EX25, EX26, EX28, EX29, EX30, EX31, EX32, EX33.

BOX FEX1	If this is the first round that EX is administered in this facility, go to EX1PRE; Else, if this is a subsequent round that EX is administered in this facility: If FEX2 has not been asked in this facility in this round for this respondent, go to FEX1PRE; Else, go to BOX FEX2.

FEX1PRE

The next series of questions ask about expenditures for room and board and ancillary charges for residents. We will need complete billing records for services provided to residents.

PRESS ENTER TO CONTINUE.

PROGRAMMER SPECS:
Set CRIN billing period length to CRIN-1 billing period length (EX6).

BOX FEX2	If this is the first SP in this round and this is the first respondent for this SP, go to FEX2; Else, if this is not the first SP in this round and this is the first respondent for this SP, and this is the first time this round the respondent has been asked EX, for any SP, go to FEX2; Else, go to EX1PRE.

FEX2

DO YOU WANT TO...

( )

1. COLLECT BILLING INFORMATION FOR ALL BILLING PERIODS, BEFORE COLLECTING ANY PAYMENT INFORMATION?

OR

2. COLLECT BILLING AND THEN PAYMENT INFORMATION FOR A BILLING PERIOD, THEN BILLING AND PAYMENT INFORMATION IN SEQUENCE FOR ALL REMAINING BILLING PERIODS?

PRESS ENTER TO CONTINUE.

FACR.BILLINFO
EXRO.COLLBILL
XFAP.BILLINF

A. CHARGES AND SOURCE OF PAYMENT MODULE

EX1PRE
Display "The first few... on FAD/RAD" if SP is a CFC, FFC, FCF, or SSM from previous fall round; else, do not display.

EX1PRE

This series of questions asks about {SP}'s expenditures for room and board and ancillary charges while a resident of {FACILITY/[READ FACILITY/UNITS ABOVE]}.

{The first few questions are about billing and sources of payment when {s/he} first became a resident here on {FAD/RAD}.

PRESS ENTER TO CONTINUE.

BOX EX0	If SP is a SSM2 from the last round, go to KEX1; else Go to BOX EX1.

BOX EX1	If FEX2 = 1, (COLLECT ALL BILLING FIRST): If in retrieval mode for CRRD-1 ancillary charges and there are additional periods to collect ancillary charges for, go to EX17; else If SP was living in an eligible part of the facility for any billing period for which expenditures data has not already been collected and this is the first billing period for which expenditures data has not already been collected, go to EX2; else If SP was living in an eligible part of the facility for any billing period for which expenditures data has not already been collected and this is the second or subsequent billing periods for which expenditures data has not already been collected, loop through EX8 through EX18 until all billing periods have been collected; then go to BOX EX7B; else Go to BOX EX7B. Else, if FEX2 = 2 (COLLECT BILLING, THEN PAYMENT FOR EACH BP), go to BOX EX7B.

KEX1
Display name of facility or unit in which the SP resided on FAD for fill for {FACILITY/[READ FACILITY UNITS ABOVE]}.

KEX1

When {SP} was first admitted to {FACILITY/[READ FACILITY UNITS ABOVE]} on {FAD}, what were all of the sources of payment for {her/his} room and board and basic care?

SELECT ALL THAT APPLY.

NO CHARGES
MEDICAID
PRIVATE PAY
SOCIAL SECURITY
SP OR SPOUSE'S OWN INCOME/ASSETS
OTHER FAMILY INCOME/ASSETS
PRIVATE INSURANCE, INCLUDING LTC INSURANCE, BC/BS
PENSION
OTHER PRIVATE PAY (SPECIFY: _____)
MEDICARE, PART A
VA CONTRACT
HMO CONTRACT
OTHER (SPECIFY:_____)
DON'T KNOW

USE ARROW KEYS. TO SELECT/DESELECT, PRESS ENTER. TO EXIT, PRESS ESC.

EXPN.KADNOCHG
.KADMCAID
.KADPRPAY
.KADSOSEC
.KADINCOM
.KADFAMIL
.KADINSUR
.KADPENS
.KADPOTHR
.KADPOS
.KADMCARE
.KADVA
.KADHMO
.KADOTHR
.KADOS

PROGRAMMER SPECS:
If "NO CHARGES" or "DON'T KNOW" is selected, do not allow any other item to be selected.
Display error message, "{NO CHARGES/DON'T KNOW} CANNOT BE SELECTED IF ANOTHER ITEM IS SELECTED."

BOX KEX1	If "NO CHARGES" was selected in KEX1, go to KEX2; else If more than one source of payment was selected in KEX1, go to KEX3; else go to EX2.

KEX2

Why were there no charges?

IF ANSWER IS "MEDICAID PAID," BACK UP TO KEX1 AND SELECT "MEDICAID."

RECORD VERBATIM.

_____

_____

_____

_____ (EX2)

VEXP.VEXPSRCE
.VEXPTXT1
.VEXPTXT2
.VEXPTXT3
.VEXPTXT4

KEX3
Display sources selected in KEX1 for answer categories.

KEX3

Which of these sources was the primary source?

SELECT ONE.

USE ARROW KEYS. TO SELECT OR DESELECT, PRESS ENTER. TO EXIT, PRESS ESC.

EXPN.KADPRMRY

EX2

(The following questions are about {SP's} basic care between {REFERENCE START DATE} and {REFERENCE END DATE}.) Was there a charge for {her/his} room and board and basic care between {REFERENCE START DATE} and {REFERENCE END DATE}? Please include any charges to {SP}, {her/his} family, or a third party, such as Medicaid, Medicare, or a legal guardian.

YES	1	(EX4)
NO	0	(EX3)
DK	-8	(EX2a)
RF	-7	(EXEND)

EXRO.ANYBASIC

EX2A
Display Facility Respondent Roster.

EX2A

Please tell me the name and title of someone in {FACILITY [READ FACILITY UNITS ABOVE]} who could give me that information.

RECORD RESPONDENT INFORMATION ON PAPER FROG.

Thank you for your time, I will need to continue with [NAME FROM FROG] to complete these questions.

PRESS ENTER TO CONTINUE.

PROGRAMMER SPECS:
Terminate Expenditures with this respondent and return to navigation screen. Set EX status on the navigate screen to RDY. The next time enter is struck on this cell, begin EX at EX1PRE.

EX3

Why were there no charges?

IF ANSWER IS "MEDICAID PAID," BACK UP TO EX2 AND ENTER "1."

RECORD VERBATIM.

_____

_____

_____

_____

VEXP.VEXPSRCE
.VEXPTXT1
.VEXPTXT2
.VEXPTXT3
.VEXPTXT4

BOX EX1A	If there are any CRIN-1 billing periods missing payment data, go to BOX EX7B; Else, go to EXEND.

EX4

Between {REFERENCE START DATE} and {REFERENCE END DATE}, was SP billed separately for health-related ancillary services? (That is, were there charges for ancillary services that were not included in the basic rate?)

IF FACILITY NEVER BILLS SEPARATELY FOR ANCILLARIES, ENTER SHIFT/5.

YES 1
NO 0

PRESS F1 FOR DEFINITION OF ANCILLARY SERVICES.

EXRO.ANCILSEP
FARO.ANCNVSEP

PROGRAMMER SPECS:
Disallow DK or RF.

MANAGEMENT SYSTEM SPECS:
If "Shift/5" is entered, set a Flag to indicate that questions about billing and payment of ancillaries (EX15PRE-EX18 and EX28-EX33) should not be asked for any SP in this Facility in this round.

BOX EX2	If EX5 has not been asked in this facility in this round, go to EX5; else go to BOX EX2A.

EX5

Through what date do you have complete billing records for the services provided to residents?

MONTH ( ) DAY ( ) YEAR ( )

FARO.COMRECMM .COMRECDD .COMRECYY .COMREC
.COMORIGY .COMORIGD .COMORIGM

PROGRAMMER SPECS:
Disallow DK or RF.
If date earlier than CRIN-1 COMREC, display error message, "THIS DATE IS BEFORE THE ONE RECORDED LAST ROUND. BE SURE YOU ASK ABOUT ALL RESIDENTS."
Hard Range: date>CRIN-1 COMREC

BOX EX2AA	If EX6 has not been asked in this facility, go to EX6; else go to BOX EX2A.

EX6

What is the length of the facility's billing period? Is it...

monthly,.....	1
every two weeks,.....	2
every week, or	3
quarterly?	4
OTHER (SPECIFY:)_____	91

FARO.BPLENGTH .BPLENGOS .XFACREXP .XPERSEXP FACL.FACBPLEN .FACBPLOS

BOX EX2A	If the SP's {REF DATE} > {DATE FROM EX5}, go to EXEND; else Go to EX7PRE.

EX7PRE

If facility bills monthly, and date from EX5 includes the last day of the month specified, display the {DATE FROM EX5}; else
If facility bills monthly and date from EX5 does not include the last day of the month specified, display the month and last day of the month preceding the month specified in EX5; else
Display {DATE FROM EX5}.

CTRL/E OK

EX7PRE

BILLING INFORMATION

FACILITY HAS UP-TO-DATE RECORDS THROUGH {DATE FROM EX5}
LENGTH OF BILLING PERIOD: {RESPONSE CODE FROM EX6.}
START WITH EARLIEST BILLING PERIOD.
COLLECT BILLING INFORMATION FROM {REFERENCE START DATE} THROUGH {REFERENCE END DATE}.

EX8
Display prefilled start date and end date if EX6 = "monthly"; else do not prefill.

CTRL/E OK

EX8

VERIFY THE START AND END DATES FOR EACH BILLING PERIOD
BP START DATE: ( )/( )/( )
BP END DATE: ( )/( )/( )

NUMBER OF DAYS IN BILLING PERIOD .....( )

BPER.BPBEGMM .BPBEGDD .BPBEGYY .BPENDMM .BPENDDD .BPENDYY .BPDAYS

PROGRAMMER SPECS:
Disallow 0, DK or RF in # OF DAYS IN BILLING PERIOD.

EX9
Display EX9 as an overlay of EX8.

EX9

Between {BP START DATE} and {BP END DATE}, how many days was {SP} billed for care?

NUMBER OF BILLED DAYS: ( )

BPER.BILLDAYS

PROGRAMMER SPECS:
Range -- EX9 ≤ EX8
If "NUMBER OF BILLED DAYS" > "NUMBER OF DAYS IN BILLING PERIOD," display the following message: "NUMBER OF BILLED DAYS, {EX9} CANNOT EXCEED NUMBER OF DAYS IN BILLING PERIOD, {EX8}."

BOX EX3	If there are any DKs or RFs in the Billing Period Start and End Date, the number of billed days (EX9) is missing or days in eligible LTC from {BP START DATE} to {BP END DATE} cannot be calculated from Residence History, go to EX11; else If the number of billed days (EX9) is not missing and the days in the billing period (EX8) = number of billed days (EX9) and number of billed days = days in eligible LTC from {BP START DATE} to {BP END DATE}, as reported in Residence History, go to BOX EX3B; else If the number of billed days (EX9) = days in eligible LTC from {BP START DATE} to {BP END DATE}, as reported in Residence History, and the days in eligible LTC < the number of days in the billing period (EX8), go to BOX EX3B; else If the number of days in the billing period (EX8) = days in eligible LTC from {BP START DATE} to {BP END DATE}, as reported in Residence History and the days in eligible LTC > number of billed days (EX9), go to EX10; else If the number of days in the billing period (EX8) > number of billed days (EX9) and number of billed days > days in eligible LTC from {BP START DATE} to {BP END DATE}, as reported in Residence History, go to EX10A; else If the number of days in the billing period (EX8) > days in eligible LTC from {BP START DATE} to {BP END DATE}, as reported in Residence History and the days in eligible LTC > number of billed days (EX9), go to EX10A; else If the number of days in the billing period (EX8) = number of billed days (EX9) and number of billed days > days in eligible LTC from {BP START DATE} to {BP END DATE}, as reported in Residence History, go to EX10A; else Go to EX10.

EX10

Can you tell me why I have a discrepancy between the number of days in this billing period, that is, {EX8} and the number of days for which {SP} was billed, that is, {EX9}?

SELECT ALL THAT APPLY.

SP DISCHARGED TO COMMUNITY
SP SENT TO HOSPITAL
SP DECEASED
SP ADMITTED AFTER BP START DATE
SP DISCHARGED TO ANOTHER NH
OTHER (SPECIFY: _____)
DK
RF

USE ARROW KEYS. TO SELECT/DESELECT, PRESS ENTER. TO EXIT, PRESS ESC. (BOX EX3B)

BPER.EX10COMM
.EX10HOSP
.EX10DEAD
.EX10AFTR
.EX10OTNH
.EX10OTHR .EX10OS

PROGRAMMER SPECS:
If DK or RF is selected, do not allow any other item to be selected. Display error message "CANNOT SELECT {DON'T KNOW/REFUSED} CATEGORY IF OTHERS ARE SELECTED."

EX10A

Earlier, I collected information that {SP} was a resident of this {nursing home/facility} for {NUMBER OF DAYS DURING BILLING PERIOD IN WHICH RH INDICATES SP WAS A RESIDENT IN ELIGIBLE LTC PLACE IN SF OR NF} days during this billing period. Yet, {s/he} was billed for {EX9} days. Can you tell me why I have this discrepancy?

SELECT ALL THAT APPLY.

SP SENT TO HOSPITAL, BED HELD
SP NOT BILLED ON ADMISSION DAY
SP NOT BILLED ON DISCHARGE DAY
SP NOT BILLED ON DATE OF DEATH
OTHER (SPECIFY: _____)
DK
RF

USE ARROW KEYS. TO SELECT/DESELECT, PRESS ENTER. TO EXIT, PRESS ESC.

PROGRAMMER SPECS:
If DK or RF is selected, do not allow any other item to be selected. Display error message, "CANNOT SELECT {DON'T KNOW/REFUSED} IF OTHERS ARE SELECTED."

BOX EX3B	If EX9 ("Number of days billed for care") = 0, go to BOX EX5; else Go to EX11.

BPER.EX10AHOS
.EX10AADM
.EX10ADIS
.EX10ADOD
.EX10AOTH
.EX10AOS

EX11
PROGRAMMER SPECS:

Display EX11 through EX14 as a three-column matrix, with EX11 and EX13 representing the first column, EX12 in the second column, and EX14 in the third column. Each row on the matrix collects one rate.

Column 1: on the first row, use the question text for EX11, and on subsequent rows use the question text for EX13. Use "ATM style" input, with the decimal point already in place.

The interviewers must completely fill out the rate they are on before adding a new rate, but they can fill the columns out in any order within that rate. They may also arrow back to previous rates and delete the row or modify columns in the row. Interviewers add new rows by pressing Enter in the third column; they will not be allowed to enter a new rate until all three columns have valid data for the current rate.

Interviewers may use control/D to delete a rate. They may not delete a rate if it is the only rate on the matrix.

Static displays. Each billing period is assigned a sequential number (if the facility bills monthly, January will be Billing Period 1, etc.). This billing period number is displayed just after the question text. The billing period start and end dates are displayed on the next line, followed by the number of billed days from EX9.

Dynamic displays. As soon as the number of days for which a rate applies has been entered in column 3, two other displays on the matrix will be dynamically updated. The first is the number of days yet to be accounted for, which is defined as the number of billed days (EX9) minus the sum of the days entered in column 3 for all rates. If column 3 is DK or RF for any rate, the number of days yet to be accounted for will be "DK." The second is the total amount billed, which is defined as the sum of the daily equivalent for each rate multiplied by the number of days for which that rate was charged. [Note that the daily equivalent is calculated using the number of days in the current month for "monthly," or 91 days for "quarterly."] If the total amount billed cannot be calculated (if some component of the rate is DK/RF, or any rate has "Other" selected in column 2), the total amount billed will be displayed as "Unknown".

Leaving the matrix. The interviewer may use Escape to leave the matrix. However, Escape will only be allowed if the number of days to be accounted for is equal to 0 (i.e., all days have been accounted for) or DK. If Escape is pressed and the number of days to be accounted is not equal to 0 or DK, display the following message at the bottom of the matrix: "The number of days to be accounted for must equal 0 or DK."

Previous billing period displays. After the first billing period, use the right side of the screen to display the billing period number, start and end dates, and number of billed days of the PREVIOUS billing period. Also, if the previous billing period had only one rate, then display the rate (on the same line as the first row in the rate matrix) and allow the interviewer to press control-A to "ditto" the previous billing period's rate into the current billing period, adjusting for the number of days. For instance, if January was billed at $100.00 per day for 31 days (total charge: $3,100.00), and the interviewer uses control-A, the "ditto" action is to copy the previous rate into the current billing period and adjust the days from 31 to 28 (total charge for February: $2,800.00).

EX11
If EX4 = 1 (YES), display {(I'll ask...services later)}; else do not display.
Display F6 only after data has been collected for first billing period.
Display "CTRL/A=ADD" only after the data has been collected for first rate.

EX11

Between {BP START DATE} and {BP END DATE}, what rate was billed for {SP's} care? {(I'll ask about billing for ancillary services later.)}
PROBE: If more than one rate was billed, please give me the first rate within the billing period.

{BP START DATE} - {BP END DATE}
OF BILLED DAYS {EX9}

{_} DAYS YET TO BE ACCOUNTED FOR
[(EX9) - (EX12+ EX14)]

TOTAL AMOUNT BILLED ${_.__}

RATE [EX11 & EX13]	UNIT DAYS [EX12 & EX14]
$.	
$.	
$.	
$.	

PER 1. DAY
2. MONTH
3. QUARTER
91. OTHER

USE ARROW KEYS. {F6=DITTO.} {CTRL/A=ADD} CTRL/D=DELETE. TO EXIT, PRESS ESC.

BRAT.BRATRATE BPER.F6STAT BPER.BASICAMT
.BRATUNIT .BRATUNOS
.BRATDAYS

PROGRAMMER SPECS:
Hard range, 0.00-99,999.99. When EX11 (BRAT.BRATRATE) and BRAT.BRATUNIT have been entered, apply the following soft range checks: BRAT.BRATUNIT=1 (DAY), Soft range = 60.00-800.00; BRAT.BRATUNIT=2 (MONTH), soft range = 1,680.00-24,800.00; BRAT.BRATUNIT=3 (QUARTER), soft range = 5,000.00-74,000.00.
For entries outside the soft range, display soft range message and leave entries displayed after the soft range message is cleared.

EX12
Display EX12 as an overlay of EX11 after the rate has been entered in EX11.

EX12

How many days were billed at that rate?

( )
NUMBER OF BILLED DAYS

BRAT.BRATDAYS

PROGRAMMER SPECS:
Hard range, 1-366, Soft range, 1-31
If NUMBER OF BILLED DAYS IN EX12 is greater than NUMBER OF BILLED DAYS in BILLING PERIOD (EX9), display message: "DAYS BILLED AT THAT RATE, {EX12}, CANNOT BE GREATER THAN DAYS BILLED IN BILLING PERIOD, {EX9}. PLEASE RE-ENTER."

BOX EX4	If all billed days in the billing period have been accounted for (EX9 - EX12 = 0), go to BOX EX5; else go to EX13.

EX13
Display EX13 as an overlay of EX12 if EX5 - EX12 … 0.

EX13

Between {BP START DATE} and {BP END DATE}, what other rate was billed for {SP's} care?

BRAT.BRATRATE
.BRATUNIT .BRATUNOS

EX14
Display EX14 as an overlay of EX13 after the rate has been entered in EX13.
If number of days billed (EX14) > number of billed days (EX9), display error message, "DAYS BILLED AT THAT RATE {EX14}, CANNOT BE GREATER THAN DAYS BILLED IN BILLING PERIOD, {EX9}. PLEASE RE-ENTER."

EX14

How many days were billed at that rate?

BRAT.BRATDAYS

PROGRAMMER SPECS:
Repeat EX13 and EX14 until all billed days in the billing period have been accounted for.

BOX EX5	If EX4 = 1 (SP billed separately for ancillaries) and billed days (EX9) > 0, go to EX15PRE; else Go to BOX EX6.

EX15PRE
If this is the first time asking this question for this respondent, this round, display ",that is, your facility's...or telephone"; else do not display.

EX15PRE

The next questions are about health-related services received by {SP} for which there was a separate charge {, that is, your facility's ancillary services. Please do not include non-health-related services such as hairdressing, television, or telephone}.

PRESS F1 FOR EXAMPLES OF NON-HEALTH-RELATED ANCILLARIES.

PRESS ENTER TO CONTINUE.

EX16

Have all charges for ancillaries been posted for the period from {BP START DATE} to {BP END DATE}?

YES	1	(EX17)
NO	0	(BOX EX6)
DK	-8	(BOX EX6)
RF	-7	(BOX EX6)

BPRO.ANCLPOST

PROGRAMMER SPECS:
If EX16 = "NO", Flag for data retrieval in next round.

EX17

Does {SP} have any ancillary charges between {BP START DATE} and {BP END DATE}?

YES	1	(EX18)
NO	0	(BOX EX6)
DK	-8	(BOX EX6)
RF	-7	(BOX EX6)

BPRO.ANYANCIL

EX18

Altogether, what was the total charge for those health-related ancillary services?

RECORD AMOUNT BELOW.

$_____

BPER.ANCILAMT

PROGRAMMER SPECS:
Hard range, $1.00-99,999.00; soft range, $1.00-$25,000.00.

BOX EX6	If this is the first round that EX is administered to in this facility: If this is the first SP in this round and this is the first respondent for this SP, go to EX19; else If this is **not** the first SP in this round and this is the first respondent for this SP and this is the first time this round the respondent has been asked EX, for any SP, go to Ex19; else Go to BOX EX7. Else, if EX was administered in this facility in CRRD-1, go to BOX EX7A.

EX19

DO YOU WANT TO ...

( )

1. COLLECT BILLING INFORMATION FOR ALL BILLING PERIODS, BEFORE COLLECTING ANY PAYMENT INFORMATION?

OR

2. COLLECT BILLING AND PAYMENT INFORMATION FOR THIS BILLING PERIOD, THEN BILLING AND PAYMENT INFORMATION IN SEQUENCE FOR ALL REMAINING BILLING PERIODS?

FACR.BILLINFO XFAP.BILLINF
EXRO.COLLBILL .EX19FLAG

PROGRAMMER SPECS:
Do not allow DK or RF.

BOX EX7	If EX19 = 1, "COLLECT ALL BILLING FIRST", loop EX8 through EX18 until all billing periods have been collected; then go to EX20; else If EX19 = 2, "COLLECT BILLING, THEN PAYMENT FOR EACH BP", go to EX20, then loop EX8 through BOX EX14 until all billing periods for which billed days > 0 have been accounted for.

BOX EX7A	If FEX2 = 1, (COLLECT ALL BILLING FIRST): If in retrieval mode for CRRD-1 ancillary charges and there are additional periods to collect ancillary charges for, go to EX17; else If SP was living in an eligible part of the facility for any billing period for which expenditures data has not already been collected and this is the first billing period for which expenditures data has not already been collected, go to EX2; else If SP was living in an eligible part of the facility for any billing period for which expenditures data has not already been collected and this is the second or subsequent billing periods for which expenditures data has not already been collected, loop through EX8 through EX18 until all billing periods have been collected; then go to BOX EX7B; else Go to BOX EX7B. Else, if FEX2 = 2 (COLLECT BILLING, THEN PAYMENT FOR EACH BP), go to BOX EX7B.

BOX EX7B	1. If EX20 for this billing period (receipt of expected payments for basic care) = NO (0) in CRIN-1, go to EX20; else go to step 2. 2. If EX28 for this billing period (receipt of expected payments for ancillaries) = NO (0) in CRIN-1 or EX17 = YES (1) and ancillary payments have not been collected for this billing period, go to EX28; else 3. For any additional billing periods for which billed days > 0 and for which payment data has not already been collected; go to EX20; else 4. Go to BOX EX21.

EX20
If EX20 has been flagged for data retrieval in CRIN-1 and this is CRIN, for the first billing period of data retrieval display "when I was last...with you now.", and for every billing period of data retrieval after the first, display "(When I was last...with you now.)"; else do not display.

CTRL/E OK {BP START DATE}-{BP END DATE}

EX20

{(When I was last here on {DATE OF CRRD-1 INTERVIEW}, you had not yet received expected payments for {SP}'s care for some of the billing periods. I'd like to review that information with you now.)}

Have you received all of the payments for basic care you expect to receive for {SP} during the [READ BILLING PERIOD ABOVE] billing period?

YES	1	(EX21)
NO	0	(BOX EX14)

BPRO.RECDBASP

PROGRAMMER SPECS:
Do not allow DK or RF.

EX21
Recalculate the "amount remaining" every time a source of payment is entered by subtracting the sum of payments from the total billed, as calculated in EX11.
If amount remaining <0, set amount remaining to "UNKNOWN".
If amount remaining <0, display error message, "Amount paid exceeds amount billed. Verify and reenter."

EX21

Please tell me the sources of payment for {SP}'s basic care for this billing period and the total amount each source paid.

{BP START DATE} - {BP END DATE}
OF BILLED DAYS {EX9}
TOTAL BILLED: ${ . }
AMOUNT REMAINING: ${ . }

MEDICAID	$	.
PRIVATE PAY	$	.
SOCIAL SECURITY	$	.
SP/FAMILY INCOME	$	.
PRIVATE INSURANCE (SEE BELOW)	$	.
PENSION	$	.
MEDICARE, PART A	$	.
VA CONTRACT	$	.
HMO CONTRACT TEXT	$	.
SUPPLEMENTAL SECURITY INCOME (SSI)	$	.
OTHER SPECIFY TEXT	$	.

USE ARROW KEYS. CTRL/A=ADD, CTRL/D=DELETE. TO EXIT, PRESS ESC.

{NAME OF INSURANCE COMPANY - MEDIGAP}
{NAME OF INSURANCE COMPANY - PRV HLTH INS}
{NAME OF INSURANCE COMPANY - LTC POLICY}
{NAME OF INSURANCE COMPANY}

PAYM.PAYMNUM .PAYMTEXT BPER.BASICPAY
.BASRATE .PAYMPLAN

PROGRAMMER SPECS:
Hard range, 0.00-99.999.99; soft range, 60.00-26,000.00.
For entries outside the soft range, display soft range message and leave entries displayed after the soft range message is cleared.

PROGRAMMER SPECS:
SPECIFICATIONS FOR DISPLAYING CATEGORIES ON THE SOURCE OF PAYMENT ROSTER (EX21 AND EX29)

The SP source of payment roster will be built in Expenditures at questions EX21 and EX29. The roster will be dynamic and fully integrated with other CAPI applications including the Facility Questionnaire, Health Status, Background, and Insurance. The link with the other applications will be a two-way link so that conducting Expenditures will not be dependent on first completing these other instruments. Formatting the source of payment questions as a dynamic roster takes advantage of the CAPI, sharing data across instruments, and will be useful when applying within and across round edit checks.

Display both EX21 and EX29 as a two-column matrix. The first column is the source of payment. The second column is the amount each source paid. Collect dollar amounts ATM style in the format $X,XXX.XX. Display four rows on the screen.

If private insurance is a source of payment, the text "PRIVATE INS (SEE BELOW)" will appear on the matrix. The verbatim text collected for the insurance company name and type of policy is displayed at the bottom of the screen, as described in the display specifications that follow.

After source(s) of payments have been collected for the first billing period, those sources selected in billing period 1 should be displayed in the billing period that follows. The pattern of payment, including any added sources, will be carried forward from each billing period into the next billing period, including across rounds.

For example, if payment data was collected in January and February, not collected in March, and collected in April and May, then data retrieval in the next round will attempt to collect payment information for the "gap", that is, March. The display for the March billing period will carry forward whatever sources of payment were entered on the source of payment roster in February, the billing period that precedes March.

Across rounds, if collection of payment data in CRIN-1 stopped in April, then CRIN-3 Expenditures data collection will begin with the billing period that follows April, that is, May. The source of payment roster for May will display sources of payment entered in April.

Following is an example of how sources of payment will be carried forward from one billing period to the next billing period, including across rounds:
(Shading indicates selection)

Billing Period 1

PRIVATE PAY

SOCIAL SECURITY
SP OR SPOUSE'S OWN INCOME/ASSETS
OTHER FAMILY INCOME/ASSETS
PRIVATE INSURANCE
MEDICARE

Billing Period 2

SOCIAL SECURITY
SP OR SPOUSE'S OWN INCOME/ASSETS
MEDICARE

F1 for Source of Payment Codes

1 MEDICAID
2 PRIVATE PAY
3 SOCIAL SECURITY
4 SP/FAMILY INCOME
5 PRIVATE INSURANCE (SPECIFY:_____)
6 PENSION
7 MEDICARE, PART A ("PART B" AT EX29)
8 VA CONTRACT
9 HMO CONTRACT (SPECIFY: _____)
10 SUPPLEMENTAL SECURITY INCOME (SSI)
91 OTHER (SPECIFY:_____)

CTRL/A to add a source of payment

In effect, using CTRL/A to add a source of payment to the SP SOP roster presents an "unfolding" payment roster for each SP. In any billing period, CTRL/A can be used to open a line to add a source of payment to the SP source of payment roster. Rather than keying in the alpha name, the interviewer will use the codes associated with sources of payment as displayed on the F1 screen (see above). If "5", "9", or "91" is selected, an overlay screen will appear for the interviewer to key in the policy name of the insurance, HMO contract, or the other source of payment.

When "PRIVATE INSURANCE" is selected, the interviewer will key in the name of the policy as given, (e.g., "Blue Cross/Blue Shield"). In both EX21 and EX29, if insurance is added, after the name of the private insurance has been specified, display either EX21a or EX29a, as appropriate, as an overlay of EX21 or EX29, respectively.

As with all SOPs selected, SOPs added to the roster should be carried forward across billing periods. For any source of payment that already appears on the SP level SOP roster, if that source is selected to be added using CTRL/A, display the following error message: "THIS SOURCE IS ALREADY ON PAYMENT ROSTER. SELECT ANOTHER SOURCE."

Example Matrix for Adding a Source of Payment

EX21
Please tell me the sources of payment for {SP}'s basic care for this billing period and the total amount each source paid.

{BP START DATE} - {BP END DATE}
OF BILLED DAYS {EX9}
TOTAL BILLED: ${ . }
AMOUNT REMAINING: ${ . }

PRIVATE PAY ..... $.
SOCIAL SECURITY..... $.
PRIVATE INSURANCE (SEE BELOW) ..... $.
OTHER SPECIFY TEXT..... $.

What is the source of payment? ( )

PRESS F1 TO SEE SOURCE OF PAYMENT CODES.

SPECIFY SOURCE OF PAYMENT:

_____

What kind of plan is that? ( )
1. MEDIGAP PLAN
2. LONG-TERM CARE PLAN
3. SOMETHING ELSE

USE ARROW KEYS. CTRL/A=ADD. CTRL/D=DELETE. TO EXIT, PRESS ESC.

{NAME OF INSURANCE COMPANY - MEDIGAP}
{NAME OF INSURANCE COMPANY - PRV HLTH INS}
{NAME OF INSURANCE COMPANY - LTC POLICY}
{NAME OF INSURANCE COMPANY} - OTHER

The overlays are blanked out upon return to the matrix. The new source of payment appears on the matrix, and the cursor is positioned to collect the amount billed for the new source of payment. If "HMO Contract" or "Other Specify" is a source of payment, display the verbatim text on the matrix. If Code 5 was entered, the name of the insurance company entered verbatim appears on the list at the bottom of the screen. If the kind of plan is DK or "3", "SOMETHING ELSE", display "OTHER" next to the name of the plan.

For each SP, for the first billing period reported, EX21 and EX29 will be formatted as SP source of payment rosters according to the specifications below.

MEDICAID

If HA47 (Medicaid #) is complete (that is, … SHIFT/5, DK or RF), display "MEDICAID"; else

If IN1 (ever covered by Medicaid) = "1", display "MEDICAID"; else

Do not display "MEDICAID".

PRIVATE PAY

Always display.

SOCIAL SECURITY

Do not display.

SUPPLEMENTAL SECURITY INCOME (SSI)

Do not display.

SP OR FAMILY'S OWN INCOME/ASSETS

Do not display.

PRIVATE INSURANCE, INCLUDING LONG-TERM CARE INSURANCE

If IN18 (Medigap/private insurance policy) = "1" display {NAME OF INSURANCE COMPANY}--PRIVATE INSURANCE

If IN20 (Long-term care insurance) = "1" display {NAME OF INSURANCE COMPANY} -- LTC POLICY; else

Do not display.

PENSION

Do not display.

MEDICARE - PART A, MEDICARE - PART B

If HA44B (Medicare #) is complete (that is, … DK or RF), display "MEDICARE - PART A" on EX21 SOP roster; else

If IN12 (covered by Medicare Part A) = "1", display "MEDICARE - PART A" on EX21 SOP roster; else do not display.

If IN13 (covered by Medicare Part B) = "1", display "MEDICARE - PART B" on EX29 SOP roster; else do not display.

VA CONTRACT

If BQ12 (active duty in Armed Forces) = "1", display "VA CONTRACT"; else

Do not display.

HMO CONTRACT

Do not display.

EX21A
Display as an overlay of EX21.

EX21A

What kind of plan is that?

MEDIGAP PLAN	1
LONG-TERM CARE PLAN	2
SOMETHING ELSE	3
DK	-8
RF	-7

PAYM.PAYMPLAN

PROGRAMMER SPECS:
If EX21A = -8 (DK), -7 (RF), or 3 (SOMETHING ELSE), display {NAME OF INSURANCE COMPANY} "- OTHER" at bottom of the billing matrix screen.

BOX EX7C	If Residence History is completed for the SP and this is the first time this round that Medicare Part A is identified as a payment source for this SP, review the Residence History timeline for a stay, of at least one day, in which place type is HOSPITAL. Review from REF DATE through the billing period in which Part A was selected/added. If there is no HOSPITAL day reported, go to EX21B; else, do not display.

EX21B {BP START DATE} - {BP END DATE}

Medicare Part A has been reported as a payment source for basic care for {SP} for [READ BILLING PERIOD ABOVE], but I have not recorded any preceding hospital stays for {him/her}.

Please tell me why Medicare paid for {SP} during this billing period.

RECORD VERBATIM BELOW. IF NECESSARY, BACK UP TO CORRECT.

IF HOSPITAL STAY IS REPORTED, RECORD DATES OF STAY BELOW.

_____

_____

_____

_____

EXRO.EX21BFLG
VEXP.VEXPSRCE
.VEXPTXT1
.VEXPTXT2
.VEXPTXT3
.VEXPTXT4

BOX EX8	After collecting all payment information for the billing period, If this is the first time this round coming to BOX EX8 for this SP, and if the difference between the "total amount paid" and the "total amount billed" is greater than 10%, If Medicaid is one of the sources of payment and the "total payments received" is 70% or more of the "total amount billed" and less than or equal to 110% of the "total amount billed", go to BOX EX9; Else, if the difference between the "total amount billed" and the "total amount paid" is greater than 10%, go to EX22; Else, go to BOX EX9; Else, if this is the second time (or greater) this round coming to BOX EX8 for this SP, and if the difference between the "total amount paid" and the "total amount billed" is greater than 10%, If EX22 = 1 (MEDICAID WRITE-OFF) or 2 (OTHER WRITE-OFF) for any previous billing period and if the "total amount paid" is 70% or more of the "total amount billed" and less than or equal to 110% of the "total amount billed", go to BOX EX9; Else, if Medicaid is one of the sources of payment and the "total payments received" is 70% or more of the "total amount billed" and less than or equal to 110% of the "total amount billed", go to BOX EX9. Else, if the difference between the "total amount billed" and the "total amount paid" is greater than 10%, go to EX22; Else, go to BOX EX9. Else, go to BOX EX9.

EX22

There seems to be a difference between what {FACILITY/[READ FACILITY/UNITS ABOVE]} billed between {BP START DATE} and {BP END DATE} and the payments received. The total amount billed I have entered for this billing period is {EX11} and the total payments for the period are {SUM OF EX21 PAYMENTS}. Why is that?

MEDICAID WRITE-OFF/ADJUSTMENT	1
OTHER WRITE-OFF/ADJUSTMENT	2
OTHER (SPECIFY:_____)	91
DK	-8
RF	-7

PRESS F1 FOR DEFINITION OF "MEDICAID WRITE-OFF".

BPER.BAS10PCT .BAS10POS
EXPN.BAS10FLG

BOX EX9	The first time Medicaid is identified as a payment source for this SP, check REF DATE and determine from Residence History where the SP was residing at that time (i.e., in which eligible LTC place) and whether that place was certified for Medicaid in that round. If the place is not certified for Medicaid, go to EX23; and The first time Medicare is identified as a payment source for this SP, check REF DATE and determine from Residence History where the SP was residing at that time and whether that place was certified for Medicare (Facility Questionnaire) in that round. If the place is not certified for Medicare, go to EX23; else Go to BOX EX9A.

EX23

I seem to have recorded some discrepant information. Earlier, I recorded that {FACILITY/UNITS NOT CERTIFIED BY MEDICAID/MEDICARE} is not certified by {Medicaid/Medicare} but I have identified {Medicaid/Medicare} as a payment source. Why would {Medicaid/Medicare} be paying for {SP's} care?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT.

_____

_____

_____

_____

EXPN.EXFCAID **EXRO.EXRFCAID**
.EXFCARE **.EXRFCARE**

VEXP.VEXPSRCE
.VEXPTXT1
.VEXPTXT2
.VEXPTXT3
.VEXPTXT4

PROGRAMMER SPECS:
Do not allow DK or RF.

BOX EX9A	For an SP whose Medicaid status in this round is "PENDING" (IN1=2), or whose Medicaid number is unknown (IN3 = -1, -8 or -7 and HA47 = -8, -7, or -5) the first time Medicaid is identified as a payment source, go to EX23A; else Go to BOX EX10, STEP 2.

EX23A
Medicaid Display.

EX23A

Please tell me {SP}'s {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number.

_____
MEDICAID ID NUMBER

DK	-8	(BOX EX10 STEP 1)
RF	-7	(BOX EX10 STEP 1)

HIRO.ECAIDNUM
PERS.MCAIDFLG

EX23B
Medicaid Display.

EX23B

I'd like to verify the {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number that I have recorded. I have entered {MEDICAID ID NUMBER}. Is this correct?

YES	1	(BOX EX10, STEP 1)
NO	0	
DK	-8	(BOX EX10, STEP 1)
RF	-7	(BOX EX10, STEP 1)

HIRO.ECAIDVER

EX23C
Medicaid Display.

EX23C

Let me enter it again. (What {is/was} {SP}'s {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number?)

_____ (EX23B)
MEDICAID ID NUMBER

DK ..... -8 (BOX EX10, STEP 1)
RF ..... -7 (BOX EX10, STEP 1)

HIRO.ECAIDNUM
PERS.MCAIDFLG

BOX EX10	1. The first time Medicaid is identified as a payment source for an SP who has not been identified in Health Insurance (IN1 = 0, -8, or -7) and Health Status (HA47 = -5) as a beneficiary of Medicaid, go to EX24 to attempt resolution; and 2. The first time Medicare is identified as a payment source for an SP who has not been identified in Health Insurance (IN12 = 0, -8 or -7) and Health Status (HA44A = 2 (SP HAS NO MEDICARE NUMBER), -8 or -7) as a beneficiary of Medicare, go to EX24 to attempt resolution; else Go to BOX EX11.

EX24
If asking about "Medicaid" display "recipient"; else display "beneficiary".

EX24

Earlier, I recorded that {SP} was not a {Medicaid/Medicare} {recipient/beneficiary} but I have identified {Medicaid/Medicare} as a source of payment. Why would {Medicaid/Medicare} be paying for {SP's} care?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT.

_____

_____

_____

_____

EXPN.EXSPCAID **EXRO.EXRSPCAD**
.EXSPCARE **.EXRSPCAR**

VEXP.VEXPSRCE
.VEXPTXT1
.VEXPTXT2
.VEXPTXT3
.VEXPTXT4

PROGRAMMER SPECS:
Do not allow DK or RF.

BOX EX11	If Medicaid is not identified as a payment source for the current billing period but appears in the preceding billing period (including if the billing period occurred in the previous round), go to EX25 to attempt resolution; else Go to BOX EX12.

EX25

It seems that I might have made a mistake in identifying the various sources of payment for {SP's} care. Earlier, I recorded that {her/his} basic charges from {FIRST BP START DATE WITH MEDICAID AS PAYER} through {LAST BP END DATE WITH MEDICAID AS PAYER} were paid by Medicaid, and in this billing period, Medicaid is no longer a payment source. Why didn't Medicaid continue to pay for {her/his} care?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT.

_____

_____

_____

_____

BPER.EXBPCAID VBPE.VBPESRCE

VBPE.VBPETXT1
.VBPETXT2
.VBPETXT3
.VBPETXT4

PROGRAMMER SPECS:
Do not allow DK or RF.

BOX EX12	If Medicare is identified as a payment source on the billing matrix, and the amount paid by Medicare represents less than 10 percent of the total payments received for the billing period, go to EX26 to attempt resolution; else Go to BOX EX14.

EX26
Display a header, the total amount paid from all sources for the billing period, and beneath it, the amount paid by Medicare. These figures are from EX21.

EX26

TOTAL PAYMENTS: {TOTAL PAYMENTS}
MEDICARE PAYMENTS: {MEDICARE PAYMENTS}

Medicare's payment for this billing period represents less than 10 percent of the total payments for basic care. Is this Medicare payment a Part B payment?

IF NECESSARY, BACK UP TO EX21 TO CORRECT PAYMENTS.

YES	1	(BOX EX14)
NO	0	(EX27)
DK	-8	(EX27)
RF	-7	(BOX EX14)

BPER.CAREPRTB

EX27

TOTAL PAYMENTS: {TOTAL PAYMENTS}
MEDICARE PAYMENTS: {MEDICARE PAYMENTS}

Can you tell me why the Medicare payment is so small?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT PAYMENTS.

_____

_____

_____

_____

VBPE.VBPESRCE
VBPE.VBPETXT1
.VBPETXT2
.VBPETXT3
.VBPETXT4

BOX EX14	If EX17 = "YES", go to EX28; else Go to BOX EX19.

EX28

Have you received all the payments you expect to receive for {SP's} ancillary services during the [READ BILLING PERIOD ABOVE] billing period?

YES	1	(EX29)
NO	0	(BOX EX19)

BPRO.RECDANCP

PROGRAMMER SPECS:
Disallow DK and RF.

EX29
Recalculate the "amount remaining" every time a source of payment is entered by subtracting the sum of payments from the total charge (EX18).

If amount remaining <0, set amount remaining to "UNKNOWN".
If amount remaining <0, display error message: "Amount paid exceeds amount billed. Verify and re-enter."

EX29

Please tell me the sources of payment for {SP}'s ancillary services for [READ BILLING PERIOD ABOVE] and the total amount each source paid.

{BP START DATE} - {BP END DATE}
OF BILLED DAYS {EX9}
TOTAL CHARGE: ${ . }
AMOUNT REMAINING: ${ . }

MEDICAID	$.
PRIVATE PAY	$.
SOCIAL SECURITY	$.
SP/FAMILY INCOME	$.
PRIVATE INSURANCE (SEE BELOW)	$.
PENSION	$.
MEDICARE-PART B	$.
VA CONTRACT	$.
HMO CONTRACT	$.
SUPPLEMENTAL SECURITY INCOME (SSI)	$.
OTHER SPECIFY TEXT	$.

USE ARROW KEYS. CTRL/A = ADD, CTRL/D = DELETE. TO EXIT, PRESS ESC.

{NAME OF INSURANCE COMPANY - MEDIGAP}
{NAME OF INSURANCE COMPANY - PRV HLTH INS}
{NAME OF INSURANCE COMPANY - LTC POLICY}
{NAME OF INSURANCE COMPANY}

PAYM.ANCRATE .PAYMTEXT BPER.ANCILPAY
.PAYMNUM .PAYMPLAN

PROGRAMMER SPECS:
See EX21.
Hard range, 0.00-99,999.00; soft range, 1-10,000.00.
For entries outside the soft range, display soft range message and leave entries displayed after the soft range message is cleared.

EX29A
Display as an overlay of EX29.

EX29A

What kind of plan is that?

MEDIGAP PLAN	1
LONG-TERM CARE PLAN	2
SOMETHING ELSE	3
DK	-8
RF	-7

PAYM.PAYMPLAN

PROGRAMMER SPECS:
If EX29A = -8 (DK), -7 (RF), or 3 (SOMETHING ELSE), display {NAME OF INSURANCE COMPANY} "- OTHER" at bottom of billing matrix screen.

BOX EX15	After collecting all payment information for the billing period, If this is the first time this round coming to BOX EX15 for this SP, and if the difference between the "total amount paid" and the "total amount billed" is greater than 10%, If Medicaid is one of the sources of payment and the "total payments received" is 70% or more of the "total amount billed" and less than or equal to 110% of the "total amount billed", go to BOX EX16; Else, if the difference between the "total amount billed" and the "total amount paid" is greater than 10%, go to EX30; Else, go to BOX EX16; Else, if this is the second time (or greater) this round coming to BOX EX15 for this SP, and if the difference between the "total amount paid" and the "total amount billed" is greater than 10%, If EX30 = 1 (MEDICAID WRITE-OFF) or 2 (OTHER WRITE-OFF) for any previous billing period and if the "total amount paid" is 70% or more of the "total amount billed" and less than or equal to 110% of the "total amount billed", go to BOX EX16; Else, if Medicaid is one of the sources of payment and the "total payments received" is 70% or more of the "total amount billed" and less than or equal to 110% of the "total amount billed", go to BOX EX16. Else, if the difference between the "total amount billed" and the "total amount paid" is greater than 10%, go to EX30; Else, go to BOX EX16. Else, go to BOX EX16.

EX30

There seems to be a difference between what {FACILITY/[READ FACILITY/UNITS ABOVE]} billed for ancillary services between {BP START DATE} and {BP END DATE} and the payments received. The total amount billed I have entered for [READ BILLING PERIOD ABOVE] {EX18} and the total payments for the period are {SUM OF EX29 PAYMENTS}. Why is that?

MEDICAID WRITE-OFF/ADJUSTMENT	1
OTHER WRITE-OFF/ADJUSTMENT	2
OTHER (SPECIFY:_____)	91
DK	-8
RF	-7

PRESS F1 FOR DEFINITION OF "MEDICAID WRITE-OFF".

BPER.ANC10PCT .ANC10POS
EXPN.ANC10FLG

BOX EX16	The first time Medicaid is identified as a payment source for this SP, check REF DATE and determine from Residence History where the SP was residing at that time (i.e., in which eligible LTC place) and whether that place was certified for Medicaid in that round. If the place is not certified for Medicaid, go to EX31; and The first time Medicare is identified as a payment source for this SP, check REF DATE and determine from Residence History where the SP was residing at that time and whether that place was certified for Medicare (Facility Questionnaire) in that round. If the place is not certified for Medicare, go to EX31; else Go to BOX EX17.

EX31

I seem to have recorded some discrepant information. Earlier, I recorded that {FACILITY/UNITS NOT CERTIFIED BY MEDICAID/MEDICARE} is not certified by {Medicaid/Medicare} but I have identified {Medicaid/Medicare} as a payment source. Why would {Medicaid/Medicare} be paying for {SP's} care?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT.

_____

_____

_____

_____

EXPN.EXFCAID **EXRO.EXRFCAID**
.EXFCARE **.EXRFCARE**

VEXP.VEXPSRCE
.VEXPTXT1
.VEXPTXT2
.VEXPTXT3
.VEXPTXT4

PROGRAMMER SPECS:
Do not allow DK or RF.

BOX EX16A	For an SP whose Medicaid status in this round is "PENDING" (IN1=2), or whose Medicaid number is unknown (IN3 = -1, -8, -7 and HA47 = -8, -7, or -5) the first time Medicaid is identified as a payment source, go to EX31A; else Go to BOX EX17, STEP 2.

EX31A
Medicaid Display

EX31A

Please tell me {SP}'s {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number.

_____
MEDICAID ID NUMBER

DK	-8	(BOX EX17, STEP 1)
RF	-7	(BOX EX17, STEP 1)

HIRO.ECAIDNUM
PERS.MCAIDFLG

EX31B
Medicaid Display.

EX31B

I'd like to verify the {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number that I have recorded. I have entered {MEDICAID ID NUMBER}. Is this correct?

YES	1	(BOX EX17, STEP 2)
NO	0	
DK	-8	(BOX EX17, STEP 1)
RF	-7	(BOX EX17, STEP 1)

HIRO.ECAIDVER

EX31C
Medicaid Display.

EX31C

Let me enter it again. (What {is/was} {SP}'s {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} ID number?)

_____ (EX31B)
MEDICAID ID NUMBER

DK ..... -8 (BOX EX17, STEP 1)
RF ..... -7 (BOX EX17, STEP 1)

HIRO.ECAIDNUM
PERS.MCAIDFLG

BOX EX17	1. The first time ever Medicaid is identified as a payment source for an SP, go to EX32 to attempt resolution, and 2. The first time ever Medicare is identified as a payment source for an SP who has not been identified in Health Insurance (IN13 = 0, -8, -7) and Health Status (HA44A = 3 (SP HAS NO MEDICARE NUMBER), -8 or -7) as a beneficiary of Medicare, go to EX32; else Go to BOX EX18.

EX32
If asking about "Medicaid," display "recipient"; else display "beneficiary".

EX32

Earlier, I recorded that {SP} was not a {Medicaid/Medicare} {recipient/beneficiary} but I have identified {Medicaid/Medicare} as a source of payment.

Why would {Medicaid/Medicare} be paying for {SP's} ancillaries?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT.

_____

_____

_____

_____

EXPN.EXSPCAID **EXRO.EXRSPCAD**
.EXSPCARE **.EXRSPCAR**

VEXP.VEXPTXT1
.VEXPTXT2
.VEXPTXT3
.VEXPTXT4

PROGRAMMER SPECS:
Do not allow DK or RF.

BOX EX18	If edit EX25 has not been triggered in BOX EX11 for the current billing period, and If Medicaid is not identified as payment source for ancillaries for the current billing period but appears in preceding period (including if the billing period occurred in the previous round), go to EX33 to attempt resolution; else Go to BOX EX19.

EX33 *CTRL/E OK*

It seems that I might have made a mistake in identifying the various sources of payment for {SP's} care. Earlier, I recorded that {her/his} charges for ancillaries from {FIRST BP START DATE WITH MEDICAID AS PAYOR} through {LAST BP END DATE WITH MEDICAID AS PAYOR} were paid by Medicaid, and in this billing period, Medicaid is no longer a payment source. Why didn't Medicaid continue to pay for {her/his} ancillary services?

RECORD VERBATIM BELOW; IF NECESSARY, BACK UP TO CORRECT.

_____

_____

_____

_____

BPER.EXBPCAID

VBPE.VBPESRCE
VBPE.VBPETXT1
.VBPETXT2
.VBPETXT3
.VBPETXT4

PROGRAMMER SPECS:
Do not allow DK or RF.

BOX EX19	If this is CRIN-1 data retrieval for ancillary charges for the next billing period are needed, go to EX17; else If this is CRIN-1 data retrieval for payments for basic care or ancillary services for the next billing period are needed, go to BOX EX7B; else Go to BOX EX20.

BOX EX20	If amounts billed for all BPs have been collected but sources of payment for all BPs in which days billed (EX9) > 0 have not, loop EX20 through BOX EX20 until all those BPs have been collected, then go to BOX EX21; else If amounts billed for all BPs have not been collected, loop EX8 through BOX EX20 until all BPs in which days billed (EX9) > 0 have been accounted for, then go to BOX EX21; else Go to BOX EX21.

BOX EX21	If private pay (Private Pay, Social Security, SP or Spouse's Own Income/Assets, Other Family Income/Assets, Private Insurance, Pension, Other Private Pay) has never been reported as a source of payment and IN20 = "YES", go to EX34; else Go to BOX EX21A.

EX34
Display "from `NAME OF INSURANCE COMPANY FROM IN28'" if it is known; else do not display.

EX34

Earlier I was told that {SP} had long-term care insurance {from {NAME OF INSURANCE COMPANY FROM IN28}}. Is it correct that this policy paid for none of {her/his} care?

YES	1	(BOX EX21A)
NO	0	(EX35)
DK	-8	(BOX EX21A)
RF	-7	(BOX EX21A)

EXRO.USENOLTC

EX35

Can you explain this to me?

RECORD VERBATIM BELOW.

_____

_____

_____

_____

VEXP.VEXPSRCE
.VEXPTXT1
.VEXPTXT2
.VEXPTXT3
.VEXPTXT4

BOX EX21A	If IN1 = pending from CRIN-1 and Medicaid has never been reported as a payment source, go to EX35A; else Go to EXEND.

EX35A
Medicaid Display.

EX35A

The last time I was here, I collected information that {SP}'s {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} eligibility status was pending. Is it still pending or has {"PREFERRED" NAME FOR MEDICAID} {(or "ALLOWED FOR" NAME FOR MEDICAID)} been denied?

STILL PENDING	1
DENIED	2
DK	-8
RF	-7

HIRO.ECAIDECO

EXEND

YOU HAVE COMPLETED THE EXPENDITURES SECTION FOR THIS SP.

PRESS ENTER TO RETURN TO NAVIGATION SCREEN.

EXPENDITURES QUESTIONNAIRE HELP SCREENS

EX4 ANCILLARY SERVICES

Ancillary services are services provided by the nursing home that are not included in the rates that cover basic care and room and board. These services may be health-related, such as radiology, drugs, therapy (physical, speech, occupational) or lab work, or non-health-related, such as beautician services, laundry, television, and so on.

The study collects expenditure data only for ancillary services that are health-related.

EX21 SOURCE OF PAYMENT CODES

EX29

1 MEDICAID
2 PRIVATE PAY
3 SOCIAL SECURITY
4 SP/FAMILY INCOME
5 PRIVATE INSURANCE (SPECIFY:_____)
6 PENSION
7 MEDICARE, PART {A/B}
8 VA CONTRACT
9 HMO CONTRACT (SPECIFY:_____)
10 SUPPLEMENTAL SECURITY INCOME (SSI)
91 OTHER (SPECIFY:_____)

EX15PRE NON-HEALTH-RELATED ANCILLARIES

Beautician services
Haircut
Laundry
Manicure
Telephone
Television
Therapeutic massage

EX22
EX30 MEDICAID WRITE-OFF

The allowable Medicaid rate for nursing home care is a figure that is set by the state, and it varies from state to state. Sometimes, a facility that is Medicaid certified may post charges for a resident that are above the allowable Medicaid rate. The difference between what the facility bills and what Medicaid pays is sometimes called a "write-off" as it is money that the facility never expects to see.